Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA, TEXAS 77504

Carrier's Austin Representative Box
Number 47

Respondent Name
AMERISURE MUTUAL INSURANCE CO

MFDR Date Received
September 9, 2005

MFDR Tracking Number
M4-06-0437

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated October 3, 2005: "...The Carrier denied payment with payment exception codes "F-Fee Guideline MAR reductions" in regard to their reduction in payment. Further, the Carrier did not complete an on-site audit. The Carrier has made no legal denial of reimbursement…"

Amount in Dispute: $14,011.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 22, 2005: "We are in receipt of your request for medical dispute resolution…"

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
November 19 to 23, 2004	Inpatient Hospital Services	$14,011.90	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee

guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- F – Fee Guideline MAR Reduction
- M – No MAR
- W3 – Additional payment made on appeal/reconsideration.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed $40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each party was given the opportunity to supplement their original Medical Dispute Resolution (MDR) submission, position or response as applicable. Neither party responded to this request for supplemental information. The documentation filed to the division by the requestor and respondent to date is considered. Consistent with the Third Court of Appeals' November 13, 2008 opinion, and 28 Texas Administrative Code §134.401(c)(6), the division will address whether the requestor demonstrated that: audited charges ***in this case*** exceed $40,000; the admission and disputed services ***in this case*** are unusually extensive; and that the admission and disputed services ***in this case*** are unusually costly.

1. The requestor in its position statement asserts that "The Carrier has made no legal denial of reimbursement." 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section." Review of the submitted documentation finds that the explanation of benefits was issued using the division-approved form TWCC 62 with payment exception codes F, M, W3, and W4.

   These payment exception codes and descriptions support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by

the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the division concludes that the total audited charges exceed $40,000.

3. The requestor in its original position statement asserts that "…if the total audited charges for the entire admission are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." In its position statement, the requestor presumes that it is entitled to the stop loss method of payment because the audited charges exceed $40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved…unusually extensive services." The requestor failed to discuss the particulars of the admission in dispute that constitute unusually extensive services. The division finds that the requestor did not meet the requirements of 28 TAC §134.401(c) (6).

4. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds $40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c)(6).

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was four days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of four days results in an allowable amount of $4,472.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." Review of the requestor's medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A).

Rev Code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
278	Screw pedicle 6x45	6x45 screw	3 @ $1150/ea	$3450.00	$3795.00
	Screw pedicle 6x35	6x35 MM pedicle screw	2 @ $1150/ea	$2300.00	$2530.00
	Screw cap	Screw caps	5 @ $450/ea	$2250.00	$2475.00
	Rod 6x70mm	Rod	1 @ $350	$350.00	$385.00
	Rod 6x60mm	Rod	1 @ $350	$350.00	$385.00
	Cage 10x12x10x8x22mm	PLIF cage 10x12x10x8x22mm	2 @$2895/ea	$5790.00	$6369.00
	PLIF cage 12/14/12x8x22mm	TI-PEEK-PLIF 12/14/12x8x22mm	2@ $2895/ea	$5790.00	$6369.00
	Putty op-1 30050	OP-1 putty	2 @ $5250/ea	$10,500.00	$11,550.00
	Vitoss 10cc flow foam 2102-1310	VT, scaf FOAM flow, cylinder (2), 26x19mm	2 @ $1200/ea	$2400.00	$2640.00
			TOTAL ALLOWABLE	$36,498.00	

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the

admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $425.00/unit for Morphine Sulphate PCA. The requestor did not submit documentation to support what the cost to the hospital was for this item billed under Revenue Code 250. For that reason, reimbursement for this item cannot be recommended.

The division concludes that the total allowable for this admission is $40,970.00. The respondent issued payment in the amount of $139,541.97. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to discuss and demonstrate that the disputed inpatient hospital admission involved unusually extensive, and unusually costly services. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		March 2013
Signature	Medical Fee Dispute Resolution	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.